

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**FOR STATE HEALTH DEPT.**

**11410**

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**11404**

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Monongalia</b> ✓			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Morgantown</b> <b>85-3</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>				d. STREET ADDRESS <b>Rt. 7</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>David</b> Last <b>Barker</b>				4. DATE OF DEATH Month <b>Aug.</b> Day <b>26th.</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 16, 1946</b>		9. AGE (In years lost birthday) <b>19</b> yrs	IF UNDER 1 Year Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>US Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Service</b>		11. BIRTHPLACE (State or foreign country) <b>Morgantown, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William P. Barker, Jr.</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Davis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>234-72-5813</b>		17. INFORMANT <b>William P. Barker, Jr. Morgantown, W. Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hemothorax, bilateral, massive</b> DUE TO (b) <b>Ruptured lung, bilateral</b> DUE TO (c) <b>Fractured ribs</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured left tibia and fibula</b>						INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>	
						<b>Minutes</b>	
						<b>Minutes</b>	
						<b>Minutes</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>In auto accident U. S. Rt. 50 4 miW. of Mt. Storm, W. Va.</b>					
20c. TIME OF INJURY Month, Day, Year <b>9:15 p.m. 8-26-66 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>(Rural) Mt. Storm Grant W. Va.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i> EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				22. DATE SIGNED CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Md. 8-27-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Lawnwood Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Morgantown W. Va.</b>	
24. FUNERAL DIRECTOR <i>Gerald D. Minnich</i> ADDRESS <b>Oakland, Maryland</b>				25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.

2011

2011

2011

9

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11411

CERTIFICATE OF DEATH

11405

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>6 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Mt. Lake Park</b> // - /			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS <b>105 East Third Avenue</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Eva</b> Middle <b>Daisy</b> Last <b>Beckman</b>				4. DATE OF DEATH Month <b>August</b> Day <b>11th</b> Year <b>19 66</b>				
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Mar. 19, 1891</b>		
9. AGE (In years last birthday) <b>75</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Terra Alta, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Ami Forman</b>				14. MOTHER'S MAIDEN NAME <b>Margaret Feather</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>220-16-6528</b>		17. INFORMANT <b>Russell T. Beckman</b> Address <b>see # 2 above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiac decompensation</b> <b>4221</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <b>Arteriosclerotic cardiovascular disease</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>3 weeks</b> <b>Years</b>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Jan.</b> , 19 <b>55</b> to <b>8-11-66</b> , 19 <b>66</b> , that (I) <b>was</b> last saw the deceased alive on <b>8-11-66</b> , 19 <b>66</b> , and that death occurred at <b>1:55</b> M, from causes and on the date stated above.								
22a. SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>8-11-66</b>		
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				22d. ADDRESS <b>104 S. 2nd. St., Oakland, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Co. Mem. Gardens Oakland, Md.</b>		23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR <i>Gerald N. Minnick</i>				ADDRESS <b>Oakland, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 15 1966</b>		
				25b. REGISTRAR'S SIGNATURE <i>Gerald N. Minnick</i>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11405

DETENTION IN GRAVE

1141

Maryland

Germany

McC. Lake Park

6 days

England

105 East Third Avenue

General County Memorial Hospital

August 11th, 1918

August

Resident

Delay

Ever

White

Female

3 weeks

Cardiac decompensation

Years

Arteriosclerotic cardiovascular disease

20

8-11-18

Jan.

8-11-18

8-11-18

James H. Foster, Jr., M.D., 101 S. 2nd St., Columbia, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11412

## CERTIFICATE OF DEATH

11406

1. PLACE OF DEATH o. COUNTY <u>Garrett</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Garrett</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u>			c. LENGTH OF STAY IN tb <u>13 Days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Oakland</u> 11-1		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Garrett County Memorial Hospital</u>				d. STREET ADDRESS <u>130 North 3rd. Street</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Foster</u> Middle <u>David</u> Last <u>Bittle</u>				4. DATE OF DEATH Month <u>August</u> Day <u>7</u> Year <u>19 66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>Dec. 12, 1894</u>		9. AGE (In years lost birthday) <u>71</u> yrs.	IF UNDER 1 YEAR Months <u>7</u> Days <u>1</u>	IF UNDER 24 HRS. Hours <u>1</u> Min. <u>00</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Supervisor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Education</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Myersville, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>America</u>	
13. FATHER'S NAME <u>Floyd David Bittle</u>				14. MOTHER'S MAIDEN NAME <u>Clara Jane Wiles</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u> <u>WW I</u>		16. SOCIAL SECURITY NO. <u>216-22-5085</u>		17. INFORMANT Address <u>Goldie Biser Bittle, Oakland, Maryland</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY OCCLUSION</u> DUE TO (c) <u>ARTERIO SCLEROSIS</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CONGESTIVE FAILURE</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>July 24</u> , 19 <u>66</u> , to <u>August 7</u> , 19 <u>66</u> , that (I) <del>(we)</del> last saw the deceased alive on <u>August 7</u> , 19 <u>66</u> , and that death occurred at <u>0540</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Dr. E. I. Baumgartner</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>8/8/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. E. I. Baumgartner</u>				22d. ADDRESS <u>Oakland, Maryland</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>8/10/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Ch. Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Myersville Md.</u>	
24. FUNERAL DIRECTOR <u>Donald N. Minnich</u>				ADDRESS <u>Oakland, Maryland</u>		25a. REC'D BY REGISTRAR <u>AUG 9 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

90411

212

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11413

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11407

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Stark</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Star Rt., Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Canton, S. W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Harold</b> Middle <b>Ray</b> Last <b>Broadwater</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>19th.</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>July 23, 1952</b>
9. AGE (In years lost birthday) yrs. <b>14</b>		10. IF UNDER 1 YEAR Months <b>14</b> Days <b>14</b> Hours <b>14</b> Min. <b>14</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Canton, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Clarence Broadwater</b>		14. MOTHER'S MAIDEN NAME <b>Hazel Bowman</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Mrs. Hazel Broadwater, see # 2 above</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Drowning</b> DUE TO (c) <b>None</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>None</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while swimming in Deep Creek Lake</b>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>10</b> <b>8-19-66</b> 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lake</b>		20f. (City or town) (County) (State) <b>Rural, Oakland Garrett Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>8-19-66</b>	
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Garr. Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 22nd., 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Sunset Hills Memorial Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Canton, Ohio</b>	
24. FUNERAL DIRECTOR <b>Gerald D. Minnick</b>		ADDRESS <b>Oakland, Maryland</b>	
25a. REC'D BY REGISTRAR <b>AUG 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114

11114



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11414

11408

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 1 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Florida</b> b. COUNTY <b>Gadsden</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Oakland</b>		c. LENGTH OF STAY IN 1b <b>10 hours.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Havana</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Swallow Falls State Forest</b>		d. STREET ADDRESS <b>Route #1, Box 29.</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First Middle Last <b>Bernard Edward Cannon</b>		4. DATE OF DEATH Month Day Year <b>August 13th. 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Colored</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 27, 1948</b>
9. AGE (In years lost, birthday) yrs. <b>17</b>		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Trainee</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Job Corps</b>	11. BIRTHPLACE (State or foreign country) <b>Havana, Florida</b>
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Melvin Cannon</b>	
14. MOTHER'S MAIDEN NAME <b>Bertha Chambers</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>	
16. SOCIAL SECURITY NO.		17. INFORMANT Address (Mother) <b>Mrs. Melvin Cannon, Havana, Florida</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO (b) <b>Drowning</b> DUE TO (c) <b>Slipped on a rock and fell into water.</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Slipped on a rock and fell into water.</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>10:30 a.m. 8-13-66 19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work <b>State Park</b>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Oakland (rural) Garr. Md.</b>	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M. D.</b>			22. DATE SIGNED <b>August 17, 1966</b>
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/21/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St. Marks Baptist</b>
23d. LOCATION (City or Town) (County) (State) <b>Tallahassee, Florida</b>		24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>	
25. REG'D BY REGISTRAR <b>AUG 17 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

20111

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11415

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11409

FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Ohio</b> b. COUNTY <b>Cuyhoga</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>Minutes</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Cleveland</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>				d. STREET ADDRESS <b>4210 Bridge Ave.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Mitchell</b> Last <b>Cecil</b>				4. DATE OF DEATH Month <b>August</b> Day <b>29th.</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Mar. 18, 1949</b>		
9. AGE (In years lost birthday) yrs. <b>17</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>		11. BIRTHPLACE (State or foreign country) <b>W. Va.</b>		
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Charles Cecil</b>				
14. MOTHER'S MAIDEN NAME <b>Faye Sadler</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				
16. SOCIAL SECURITY NO. <b>269-44-8888</b>				17. INFORMANT <b>Mrs. Faye Sadler see # 2 above</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Aspiration of stomach contents</b> DUE TO (c) <b>Subdural hemorrhage secondary to contusion of brain</b>							INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Subdural hemorrhage secondary to contusion of brain</b>							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Driver of auto that wrecked on U. S. 219</b>					
20c. TIME OF INJURY Month, Day, Year <b>8:40 p.m. 8-29-66 19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>Rural, Oakland Garrett Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>				M.D. <b>James H. Feaster, Jr., M. D.</b>				
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>				22. DATE SIGNED <b>8-30-66</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>9/2/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>West Park Cemetery</b>		
23d. LOCATION (City or Town) (County) (State) <b>Cleveland Ohio</b>				25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>				
24. FUNERAL DIRECTOR <b>Gerald D. Minnich</b>				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>				

8-11-11

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11416

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

11410

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Frederick</b> ✓		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>30 minutes</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Fredrick</b> 10-2		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>			d. STREET ADDRESS <b>Box 10, Rt. 4</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Beverly</b> Middle <b>Elaine</b> Last <b>DeMoss</b>			4. DATE OF DEATH Month <b>August</b> Day <b>21st.</b> Year <b>19 66</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 28, 1930</b>		9. AGE (In years last birthday) yrs. <b>36</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Seamstress</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Tailoring Co.</b>		11. BIRTHPLACE (State or foreign country) <b>Pennsylvania</b>	
13. FATHER'S NAME <b>Milton J. McElhany</b>			14. MOTHER'S MAIDEN NAME <b>Mae E. ?</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-28-7375</b>		17. INFORMANT <b>Donald A. DeMoss, Frederick, Md.</b> Address (Husband)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute pulmonary edema</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Bronchial asthma, acute</b> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH <b>2 hours</b> <b>2 hours</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
		20f. (City or town)		(County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D.		22. DATE SIGNED <b>8-21-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>	
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		Address (Street, city, town, or county) <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/24/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt Olivet Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick, Maryland</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b>		ADDRESS <b>Leighton-Durst Funeral Home, Oakland, Md.</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 23 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11111

11417

**CERTIFICATE OF DEATH**

11411

<b>1. PLACE OF DEATH</b> a. COUNTY <u>GARRETT</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE</u> c. LENGTH OF STAY IN lb <u>LIFE</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>GARRETT</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>RURAL GRANTSVILLE 11-1</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>CORDELLA GERTRUDE DURST</u> First Middle Last			<b>4. DATE OF DEATH</b> <u>AUG 18 1966</u> Month Day Year				
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>N</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>FEB 28 1910</u>	<b>9. AGE</b> (In years last birthday) <u>56</u> yrs.	IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>OWN HOME</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>FROSTBURG MD</u>			
<b>13. FATHER'S NAME</b> <u>GEORGE CARLITZ</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>ANNA ROBESON</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> <u>Raymond Durst Grantsville RD 2 MD</u> Address			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial infarction</u> DUE TO (b) <u>coronary artery disease</u> DUE TO (c) <u>arteriosclerotic changes</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>Sudden</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b> <u>Heart disease, hypertension &amp; arteriosclerotic</u>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. 19 p.m.	<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)			
<b>21. I certify that (I) (this hospital)</b> attended the deceased from <u>June 1953</u> to <u>17 Aug 1966</u> , that (I) ( <del>was</del> ) last saw the deceased alive on <u>Aug 17 1966</u> , and that death occurred at <u>8P</u> M, from causes and on the date stated above.							
<b>22a. SIGNATURE</b> <u>Grant Atwell M.D.</u>			<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b> <u>20 Aug 66</u>		
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Grant Atwell</u>			<b>22d. ADDRESS</b> <u>Meyersdale, Pa.</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>BURIAL</u>	<b>23b. DATE THEREOF</b> <u>8/21/66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>NEW GERMANY</u>		<b>23d. LOCATION</b> (City or Town) (County) (State) <u>GRANTSVILLE GARRETT MD</u>			
<b>24. FUNERAL DIRECTOR</b> <u>Don Hawman Grantsville Md</u> ADDRESS			<b>25a. REC'D BY REGISTRAR</b>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		
DATE <u>AUG 23 1966</u>							

MEDICAL CERTIFICATION

**TO HOSPITAL OR ATTENDING PHYSICIAN:** The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

• • •



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11418

## CERTIFICATE OF DEATH

11412

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>2 mos. - 6 1/2 days</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Rt. # 2 - Box 261</b>	
3. NAME OF DECEASED (Type or print) First <b>Homer</b> Middle <b>Leslie</b> Last <b>Gnegy</b>		4. DATE OF DEATH Month <b>August</b> Day <b>10</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>January 28, 1890</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Garrett, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
13. FATHER'S NAME <b>David Gnegy</b>		14. MOTHER'S MAIDEN NAME <b>Clara Emma Hauser</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.	
17. INFORMANT		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Larcinomatosis due to</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Larcinoma prostate</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>4 mos</b> <b>1 1/2 yrs</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MARCH 22, 19 66</b> to <b>AUGUST 10, 19 66</b> , that (I) (we) last saw the deceased alive on <b>AUGUST 10, 19 66</b> , and that death occurred at <b>2:15 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>A. E. Mance</b>		22b. DATE SIGNED <b>10 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. E. Mance</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>August 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Red House Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Oakland Garrett Md.</b>
24. FUNERAL DIRECTOR <b>Lester L. Hinkle</b>		25a. REC'D BY REGISTRAR <b>Davis, W. Va.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>AUG 17 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL: ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon-pages. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11419 Item #8 Film #G380 9/16/66 11413											
1. PLACE OF DEATH											
a. COUNTY Garrett				b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland				c. LENGTH OF STAY IN 1b 20 yrs.			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 419 E. Alder St.				e. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
a. STATE Maryland				b. COUNTY Garrett				c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Oakland			
d. STREET ADDRESS 419 E. Alder St.				e. DATE OF DEATH August 20, 1966				f. DAY 20, 1966			
3. NAME OF DECEASED (Type or print) Ruth Eleanor Gonder				4. DATE OF DEATH August 20, 1966				5. SEX Female			
6. COLOR OR RACE White				7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				8. DATE OF BIRTH Aug. 22, 1915			
9. AGE (In years last birthday) 50 yrs.				10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife				11. BIRTHPLACE (County & State, or foreign country) Wilkinsburg, Penna.			
12. CITIZEN OF WHAT COUNTRY? USA				13. FATHER'S NAME Harry Schoeller				14. MOTHER'S MAIDEN NAME Marie Whalen			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war and dates of service) no				16. SOCIAL SECURITY NO. 210-03-7681				17. INFORMANT Lindsay A. Gonder, Sr. see #2 above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)											
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarct</i> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b) <i>Coronary Atherosclerosis</i> (c) <i>8 years</i>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
MEDICAL CERTIFICATION											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)											
20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19											
20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>											
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)											
20f. (City or town) (County) (State)											
21. I certify that (I) (this hospital) attended the deceased from 11/17/58, 19 to 8/12/66, 19, that (I) (we) last saw the deceased alive on 8/19/66, and that death occurred at 5P.M. from the causes and on the date stated above.											
22a. SIGNATURE <i>Herbert H. Leighton</i> M.D.											
22b. DATE SIGNED <i>23 Aug 66</i>											
22c. PHYSICIAN'S NAME (Type) Herbert H. Leighton, M.D.											
22d. ADDRESS Oak at Fifth Oakland, Md. 21550											
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial											
23b. DATE THEREOF 8/23/66											
23c. NAME OF CEMETERY OR CREMATORY Garrett County Mem. Gardens Oakland, Maryland											
23d. LOCATION (City, town or county) (State)											
24. FUNERAL DIRECTOR'S SIGNATURE ADDRESS <i>Gerald D. Minnich</i> Oakland, Maryland											
25a. REC'D BY REGISTRAR DATE AUG 29 1966											
25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>											

11113

11113

UNITED STATES OF AMERICA

11113

11113

11113

UNITED STATES OF AMERICA  
DEPARTMENT OF THE ARMY  
OFFICE OF THE CHIEF OF STAFF  
WASHINGTON, D. C. 20315  
MEMORANDUM FOR THE RECORD  
SUBJECT: [Illegible]

1. [Illegible]  
2. [Illegible]  
3. [Illegible]  
4. [Illegible]  
5. [Illegible]  
6. [Illegible]  
7. [Illegible]  
8. [Illegible]  
9. [Illegible]  
10. [Illegible]

11. [Illegible]  
12. [Illegible]  
13. [Illegible]  
14. [Illegible]  
15. [Illegible]  
16. [Illegible]  
17. [Illegible]  
18. [Illegible]  
19. [Illegible]  
20. [Illegible]

21. [Illegible]  
22. [Illegible]  
23. [Illegible]  
24. [Illegible]  
25. [Illegible]  
26. [Illegible]  
27. [Illegible]  
28. [Illegible]  
29. [Illegible]  
30. [Illegible]

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11414

11420

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN Ib <b>36 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Vindex</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Meshac</b> Middle <b>Ellsworth</b> Last <b>Harvey</b>				4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	8. DATE OF BIRTH <b>2/7/85</b>		9. AGE (In years last birthday) <b>81</b> yrs.	IF UNDER 1 YEAR Months <b>11</b> Days <b>1</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner - retired</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Vindex, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Michael Harvey</b>				14. MOTHER'S MAIDEN NAME <b>Ruth Tasker</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>218-10-8993</b>		17. INFORMANT <b>Mrs. Lyle Sharpless, Vindex, Md.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Vascular Accident</b> 422.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerotic Cardio Vascular Disease</b> DUE TO (c) <b>Unknown</b>						INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>July 19</b> , 19 <b>66</b> , to <b>August 26</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>August 26</b> , 19 <b>66</b> , and that death occurred at <b>3:55 AM</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Robert H. Leighton</b> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>26 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. H. Leighton</b>				22d. ADDRESS <b>Oakland, Maryland 21550</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Aug. 28/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>R.D. Swanton, Md.</b>	
24. FUNERAL DIRECTOR <b>Amy Mildred Sharpless</b> ADDRESS <b>Blaine, W. Va. P.O. Kitzmiller, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 30 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

11111

RECEIVED TO THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE

THE



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File Pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal of the body. Any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11421

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11415

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>W. Va.</b> b. COUNTY <b>Marion</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN Tb <b>Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Tracy</b> Middle <b>Lee</b> Last <b>Hawkins</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>26th.</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 30, 1945</b>
9. AGE (In years last birthday) <b>20</b> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Serviceman</b>	10b. KIND OF BUSINESS OR INDUSTRY <b>US Navy</b>
11. BIRTHPLACE (State or foreign country) <b>Fairmont, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Issac Hawkins</b>		14. MOTHER'S MAIDEN NAME <b>Kathleen Nallon</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO. <b>233-70-5569</b>	
17. INFORMANT <b>Kathleen Hawkins</b>		Address <b>see #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <b>8254</b> IMMEDIATE CAUSE (a) <b>Hemothorax, bilateral, massive</b> DUE TO (b) <b>Ruptured lungs</b> DUE TO (c) <b>Fractured ribs.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Fractured pelvis. Ruptured spleen</b>			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <b>Driver of auto that wrecked U. S. Rt. 50 4mi. W. Mt. Storm</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Highway</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:15 p.m. 8-26-66 19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Rural Mt. Storm Grant W. Va.</b>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>Oakland, Md. 8-27-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Zion Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Fairmont W. Va.</b>	
24. FUNERAL DIRECTOR <b>Gerald N. Minnich</b>		25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

111



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

<div style="display: flex; justify-content: space-between;"> <span>11422</span> <span>MARYLAND STATE DEPARTMENT OF HEALTH</span> <span>11416</span> </div> <div style="text-align: center;"> <b>DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND</b>  <b>CERTIFICATE OF DEATH</b> </div>																					
<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> <div style="text-align: center;"><b>MARYLAND</b></div> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>						<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>															
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Main Street</b>						d. STREET ADDRESS <b>Main Street</b>															
<b>3. NAME OF DECEASED</b> (Type or print) <b>DELLA MAY HERSHBERGER</b>						<b>4. DATE OF DEATH</b> Month <b>AUGUST</b> Day <b>5</b> Year <b>19 66</b>															
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>B. DATE OF BIRTH</b> <b>June 7, 1886</b>		<b>9. AGE</b> (In years last birthday) <b>80</b> yrs. <table border="1"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> <tr> <td></td> <td></td> <td></td> <td></td> </tr> </table>		IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.				
IF UNDER 1 YEAR		IF UNDER 24 HRS.																			
Months	Days	Hours	Min.																		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>Housework</b>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <b>Own Home</b>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <b>Elk Garden, W.Va.</b>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>													
<b>13. FATHER'S NAME</b> <b>Perry Street</b>						<b>14. MOTHER'S MAIDEN NAME</b> <b>Anna Rebecca Groves</b>															
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)						<b>16. SOCIAL SECURITY NO.</b> <b>213-50-1072</b>															
<b>17. INFORMANT</b> <b>Mrs. Charles Davis-Kitzmiller, Md.</b>																					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary Thrombosis (Acute)</b> <div style="display: flex; justify-content: space-between;"> <div>             4201              Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.           </div> <div>             DUE TO (b) <b>Coronary Heart Disease</b>              DUE TO (c) <b>Arteriosclerosis</b> </div> </div>										<b>INTERVAL BETWEEN ONSET AND DEATH</b> <b>1 1/2 yrs</b> <b>3 yrs</b>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)																					
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)															
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <b>19</b>			<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <b>Elk Garden</b>		<b>(County)</b> <b>Mineral</b>		<b>(State)</b> <b>W.Va.</b>										
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>Aug 2</b> , 19 <b>66</b> , <b>5 P.M.</b> <b>to</b> <b>Aug 5</b> , 19 <b>66</b> , <b>5 P.M.</b> , that (I) (we) last saw the deceased alive on <b>Aug 2</b> , 19 <b>66</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.																					
<b>22a. SIGNATURE</b> <b>Ralph Calandrella</b>						<b>22b. DATE SIGNED</b> <b>August 7-66</b>															
<b>22c. PHYSICIAN'S NAME</b> <b>Dr. Ralph Calandrella</b>						<b>22d. ADDRESS</b> <b>Kitzmiller, Md. 21538</b>															
<b>23a. BURIAL, CREMATION, OR OTHER DISPOSAL</b> <b>Burial</b>				<b>23b. DATE THEREOF</b> <b>8/8/66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>I.O.O.F. Cemetery</b>				<b>23d. LOCATION</b> (City, town or county) (State) <b>Elk Garden, Mineral Co. W.Va.</b>											
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Amy Mildred Sharpless</b>						<b>25a. REC'D BY REGISTRAR</b> <b>DATE AUG 9 1966</b>															
<b>ADDRESS</b> <b>Blaine, W.Va.</b>						<b>25b. REGISTRAR'S SIGNATURE</b> <b>J. Charles Judge</b>															

0111

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

11417

11423

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland - Rural</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		d. STREET ADDRESS <b>Route #1, Box # 275.</b>	
3. NAME OF DECEASED (Type or print) First <b>Guy</b> Middle <b>Hinebaugh</b> Last <b>Hinebaugh</b>		4. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1/19/96</b>
9. AGE (In years last birthday) <b>70</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b>	IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Restaurant Owner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Restaurant</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Oakland, Garrett, Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>William Glotfelty Hinebaugh</b>		14. MOTHER'S MAIDEN NAME <b>Molly Martin</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no or unknown) (If yes give year or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>214-32-2842</b>	
17. INFORMANT (Self) <b>Guy Hinebaugh</b>		Address <b>Oakland, Maryland</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Malabsorption Syndrome</b> DUE TO <b>Chronic Enteritis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Chronic Enteritis</b> DUE TO <b>Chronic Enteritis</b> (c) <b>Chronic Enteritis</b>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chronic Cystitis - Nephritis - Deformed Hip</b>			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan 3</b> , 19 <b>49</b> , to <b>Aug 3</b> , 19 <b>66</b> , that (I) (we) last saw the deceased give an <b>Aug 3</b> , 19 <b>66</b> , and that death occurred at <b>2:55 AM</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Dr. E. I. Baumgartner</b>		22b. DATE SIGNED <b>8/3/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. E. I. Baumgartner</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/5/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Garr. C. Mem. Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 5 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

11111

1111

RECEIVED  
JAN 11 1961  
U.S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# CERTIFICATE OF DEATH

11424

11418

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN lb <b>3 DAYS</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>DEER PARK</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>JOHN</b> Middle <b>F.</b> Last <b>HIPP</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>25</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	B. DATE OF BIRTH <b>JUNE 20, 1881</b>		9. AGE (In years last birthday) <b>85 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miller</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>COAL</b>		11. BIRTHPLACE (County & State, or foreign country) <b>IOWA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JOHN FRANK HIPP</b>				14. MOTHER'S MAIDEN NAME <b>LUCINDA BOSLEY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-09-3261</b>		17. INFORMANT <b>Howard Hipp</b> Address <b>MT. Storm, W.Va.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Uremia</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Pneumonitis</b> DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <b>2 weeks</b> <b>1 week</b>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Arteriosclerosis, generalized</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>8-22-66</b> , 19 to <b>8-25-66</b> , 19, that (I) (we) last saw the deceased alive on <b>8-25-66</b> , 19, and that death occurred at <b>7:35 P</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>James H. Feaster Jr.</i>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>DR. JAMES FEASTER, JR.</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8-28-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>North Hill</b>		23d. LOCATION (City or Town) (County) (State) <b>Elk Garden W.Va.</b>	
24. FUNERAL DIRECTOR <b>Robert Kyle Pitts Jr.</b>				ADDRESS <b>Kelly Miller, Ind.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 1966</b>	
				25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

81411

OFFICE OF THE ATTORNEY GENERAL

State

FILE

DATE

TIME

BY

1900

100

100

100

100

100

100

100

100

100

100

RECEIVED  
JAN 10 1900  
STATE OF NEW YORK  
OFFICE OF THE ATTORNEY GENERAL  
ALBANY



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11419

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Montgomery</b> ✓	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>Minutes</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>(DOA) Garrett Co. Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Linwood Edward James</b>		4. DATE OF DEATH <b>August 15th, 19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>X Sept. 26, 1946 19</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Student</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>School</b>	
11. BIRTHPLACE (State or foreign country) <b>Montgomery Co., Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Charles E. James</b>		14. MOTHER'S MAIDEN NAME <b>Pauline Johnson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>225-58-8355</b>	
17. INFORMANT <b>Mr. Charles E. James</b>		Address <b>see #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <b>8254</b> IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Hemorrhage</b> DUE TO (c) <b>Ruptured liver</b>		INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b> <b>Minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured ribs, right</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Auto accident on Turkey Neck Road</b>	
20c. TIME OF INJURY Month, Day, Year <b>9:15 8-15-66 19</b>		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>		20f. (City or town) (County) (State) <b>(Rural) Deer Park Carr. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22. DATE SIGNED <b>8-15-66</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/18/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Roselawn Memory Gardens</b>	23d. LOCATION (City or Town) (County) (State) <b>Blacksburg, Va.</b>
24. FUNERAL DIRECTOR <b>Gerald N. Minnick</b>		25a. REC'D BY REGISTRAR <b>AUG 18 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

01111

San Antonio, Texas  
San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas

San Antonio, Texas



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11426

CERTIFICATE OF DEATH

11420

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>17 Hours</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Accident</b>		11-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		d. STREET ADDRESS <b>11-1</b>	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>John</b> Middle <b>(none)</b> Last <b>Kahl</b>		4. DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>19 66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/25/78</b>
9. AGE (In years last birthday) <b>88</b> yrs.		IF UNDER 1 YEAR Months <b>88</b> Days <b>26</b> Hours <b>17</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED FARMER</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>FARMING</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Accident, Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>America</b>	
13. FATHER'S NAME <b>Ludwig Kahl</b>		14. MOTHER'S MAIDEN NAME <b>CATHERINE LANTZ</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>Harold Kahl (son)</b>	
17. INFORMANT <b>Accident, Md.</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> DUE TO <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>24 hrs.</b> <b>Years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>8-26-66</b> , 19 <b>8-26-66</b> , that (I) (we) last saw the deceased alive on <b>8-25-66</b> 19 <b>8-25-66</b> , and that death occurred at <b>1:56 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		22b. DATE SIGNED <b>8-26-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		22d. ADDRESS <b>104 S. 2nd. St., Oakland, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>8/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>ZION LUTHERAN</b>		23d. LOCATION (City or Town) (County) (State) <b>ACCIDENT, GARRETT CO., MD</b>	
24. FUNERAL DIRECTOR <b>Don J. Newman, Grantsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 31 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

11750

RECEIVED

11750



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-8. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

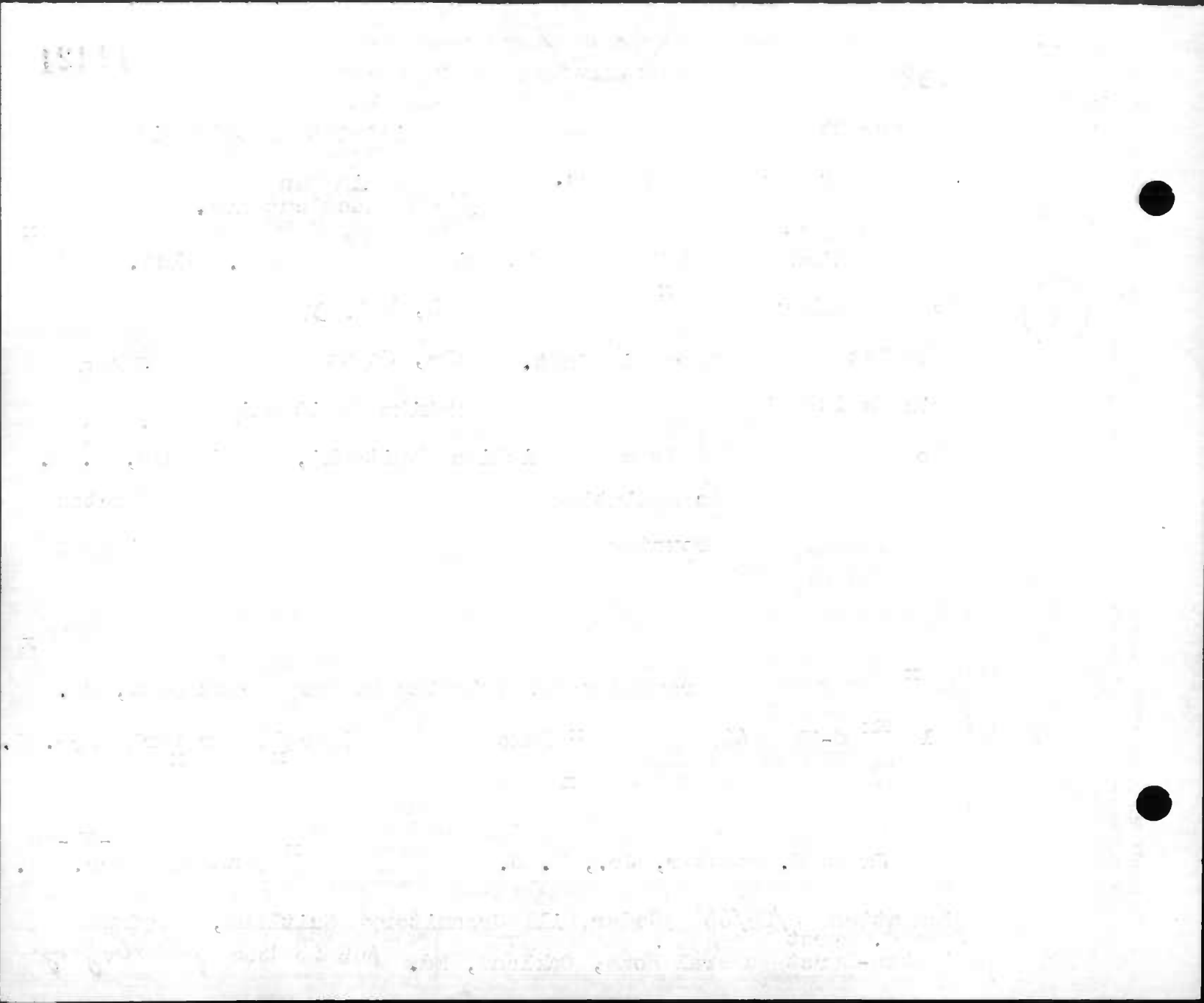
1  
2  
MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11427

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11421

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>District of Columbia</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>(Rural) Deer Park</b>		c. LENGTH OF STAY IN lb <b>36 hrs.</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Deep Creek Lake</b>		d. STREET ADDRESS <b>4250 Connecticut Ave. 5241 Broad Branch Road</b>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <b>Akira (NMI) Kamitsuki</b>		4. DATE OF DEATH Month <b>Aug.</b> Day <b>21st.</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Yellow</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>June 1, 1929</b>
9. AGE (In years last birthday) <b>37</b> yrs.		IF UNDER 1 Year Months <input type="checkbox"/> Days <input type="checkbox"/> IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during last year, if working, or even if retired) <b>Geologist</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Carnegie Inst.</b>	
11. BIRTHPLACE (State or foreign country) <b>Osaka, Japan</b>		12. CITIZEN OF WHAT COUNTRY? <b>Japan</b>	
13. FATHER'S NAME <b>Yukio Kamitsuki</b>		14. MOTHER'S MAIDEN NAME <b>Takiko Kamitsuki</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>None</b>	
17. INFORMANT <b>Michiko Kamitsuki, Washington, D. C.</b>		Address (Widow)	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Asphyxiation</b> <b>9298</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } (b) <b>Drowning</b> DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH <b>Minutes</b> <b>Minutes</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Drowned while swimming in Deep Creek Lake, Md.</b>	
20c. TIME OF INJURY Month, Day, Year <b>1</b> Hour <b>8-21</b> 19 <b>66</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Lake</b>	20f. (City or town) (County) (State) <b>(Rural) Deer Park Garr. Md.</b>
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <b>Oakland Garr. Md.</b>	
22. DATE SIGNED <b>8-21-66</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>	23b. DATE THEREOF <b>8/25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Cedar Hill Crematory</b>	23d. LOCATION (City or Town) (County) (State) <b>Suitland, Maryland</b>
24. FUNERAL DIRECTOR <b>John Leighton-Durst</b>		25a. REC'D BY REGISTRAR <b>AUG 23 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 must be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 7-62

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
11428						11422					
1. PLACE OF DEATH						2. USUAL RESIDENCE (Where deceased lived, if institution; residence before admission)					
a. COUNTY <b>Garrett</b> MARYLAND						a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>					
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>						c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Deer Park</b>					
c. LENGTH OF STAY IN 1b <b>1 mos.</b>						d. STREET ADDRESS <b>Rt. 2</b>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Cuppert-Weeks Nursing Home</b>						e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print)						4. DATE OF DEATH					
First <b>Ashful</b> Middle <b>Harmon</b> Last <b>King</b>						Month <b>Aug.</b> Day <b>29</b> Year <b>1966</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Feb. 16, 1882</b>		9. AGE (In years last birthday) <b>84</b> yrs.		IF UNDER 1 YEAR Months <b>84</b> Days <b>84</b> Hours <b>84</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Deer Park, Md.</b>				12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Emmanuel King</b>						14. MOTHER'S MAIDEN NAME <b>Claire Paugh</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Charles King</b>				Address <b>Bunola., Penna.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										INTERVAL BETWEEN ONSET AND DEATH <b>none</b>	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (e) <b>myocardial infarction</b>											
4201 DUE TO											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) <b>hypertensive CV disease</b>											
(c)											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)											
<b>carcinomatosis - carcinoma of prostate</b>											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>						20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Sept 19 65</b> to <b>29 Aug 66</b> , that (I) (we) last saw the deceased alive on <b>20 Aug 66</b> , 19 <b>66</b> , and that death occurred at <b>3:35 P.M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>B L Green</b>						M.D.		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>31 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>B L Green MD</b>						22d. ADDRESS <b>Oakland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>				23b. DATE THEREOF <b>9/1/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Deer Park Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Deer Park Maryland</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>Gerald H. Minnich</b>						ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

11455

UNITED STATES OF AMERICA

11455

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH

DEATH



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11429

## CERTIFICATE OF DEATH

11423

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>				c. LENGTH OF STAY IN 1b <b>1 DAY</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS <b>410 "K" STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>ERNEST</b> Middle <b>JOSEPH</b> Last <b>MC ROBIE</b>				4. DATE OF DEATH Month <b>AUGUST</b> Day <b>11</b> Year <b>1966</b>			
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>MAY 20, 1889</b>		9. AGE (In years last birthday) <b>77</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal</b>		11. BIRTHPLACE (County & State, or foreign country) <b>GARRETT-MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>JOHN MC ROBIE</b>				14. MOTHER'S MAIDEN NAME <b>Harriett <del>HEATIE</del> SMITH</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW I</b>		16. SOCIAL SECURITY NO. <b>213-18-2361</b>		17. INFORMANT Address <b>MT. LAKE PARK, W-CLARA ELLEN MC ROBIE-410 "K" STREET MD.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Congestive Failure</b> DUE TO (c) <b>Arteriosclerotic CV.</b>						INTERVAL BETWEEN ONSET AND DEATH <b>4201</b> <b>2 mos.</b> <b>yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>emphysema asthma diabetes mellitus</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>66</b> , to <b>AUGUST 11</b> 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>AUGUST 11</b> , 19 <b>66</b> , and that death occurred at <b>10:30 P.M.</b> at <b>home</b> and on the date stated above.							
22a. SIGNATURE <b>B. L. Grant</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>12 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>DR. B. L. GRANT</b>				22d. ADDRESS <b>OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/14/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ferndale Baptist Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Near Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>John O. Durst</b> <b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 15 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

65411

52



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1

M

CERTIFICATE OF DEATH

11430

11424

1. PLACE OF DEATH a. COUNTY <u>GARRETT</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>GARRETT</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY RD</u>		c. LENGTH OF STAY IN 1b <u>10 YRS</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SALISBURY, RD #</u>		d. STREET ADDRESS <u>11-1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>FRANK</u> First <u>MILLER</u> Middle <u>LAST</u> Last		4. DATE OF DEATH Month <u>Aug</u> Day <u>6</u> Year <u>1966</u>	
5. SEX <u>m</u>	6. COLOR OR RACE <u>w</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 24 1892</u> 74 yrs.
9. AGE (In years last birthday) <u>74</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARPENTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>CARPENTER W.O.R</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>ECKHART, MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>WILLIAM MILLER</u>		14. MOTHER'S MAIDEN NAME <u>ELLEN HOOVER</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, na, or unknown) (If yes give wor or dates of service)		16. SOCIAL SECURITY NO. <u>220-10-2994</u>	
17. INFORMANT <u>Mrs. Martha Miller Salisbury Rd Pa</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary artery disease</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>5 yr</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Aug 5 1966</u> to <u>Aug 6 1966</u> , that (I) (we) last saw the deceased alive on <u>Aug 5 1966</u> and that death occurred at <u>6:10 AM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Ross Rumbaugh M.D.</u>		22b. DATE SIGNED <u>8/6/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>ROSS RUMBAUGH M.D.</u>		22d. ADDRESS <u>Meyersdale, Pa</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>8/8/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>GRANTSVILLE</u>	23d. LOCATION (City or Town) (County) (State) <u>GRANTSVILLE GARRETT MD</u>
24. FUNERAL DIRECTOR <u>Don Newman Grantsville, Md</u>		25a. REC'D BY REGISTRAR DATE <u>AUG 11 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

11154

STATE OF TEXAS

11154

Blank document with faint horizontal lines and two punch holes on the right side.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 should be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR AIS (4)  
15M 7-62

MAYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MAYLAND									
11431					11425				
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)				
a. COUNTY		Garrett			a. STATE		b. COUNTY		
		MARYLAND			Maryland		Garrett		
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)				
Oakland			2 mos.		Deer Park				
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)					d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>		
Oak Rest Nursing Home					Rt. 2		11-1		
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH		5. SEX		
First Middle Last					Month Day Year				
John Edward Miller					August 18, 1966				
5. SEX		6. COLOR OR RACE		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH		9. AGE (In years last birthday)	
Male		White		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Feb. 23, 1882		84 yrs.	
								IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)			10b. KIND OF BUSINESS OR INDUSTRY			11. BIRTHPLACE (County & State, or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
Farmer			Farming			Deer Park, Md.		USA	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME				
David Miller					Eliza Hetrick				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT Address				
no			200-07-3653		Mrs. Anna Miller see #2 above				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)								INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) myocardial infarction								mins.	
4201 DUE TO									
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) Pulmonary CO Disease								years.	
DUE TO (c)									
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)								19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
diabetes mellitus emphysema									
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Hour a.m. p.m.		Month, Day, Year		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
		19							
21. I certify that (I) (this hospital) attended the deceased from Nov. 3, 1966, to May 1966, that (I) (we) last saw the deceased alive on 17 Aug. 1966, and that death occurred at 2 p.m. from the causes and on the date stated above.									
22a. SIGNATURE					ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED		
B. H. Grant M.D.							19 Aug 66		
22c. PHYSICIAN'S NAME (Type)					22d. ADDRESS				
B. H. Grant M.D.					Oakland, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City, town or county) (State)			
Burial		8/21/66		Garrett Co. Mem. Gardens		Oakland, Maryland			
24. FUNERAL DIRECTOR'S SIGNATURE					ADDRESS		25a. REC'D BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		
Gerald N. Minnich					Oakland, Maryland		AUG 22 1966 J. Charles Judge		

18035

4511

1870

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 8. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

item 9, Film G379 8/19/66 mh

11432

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11426

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Delaware</b> b. COUNTY <b>New Castle</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>1 hour</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett Co. Memorial Hospital</b>		d. STREET ADDRESS <b>102 NE West Edinburgh Dr.</b>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ann</b> Last <b>Rogers</b>		4. DATE OF DEATH Month <b>August</b> Day <b>5th.</b> Year <b>19 66</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Sept. 20, 1932</b>
9. AGE (In years lost birthday) yrs. <b>33 32</b>		10. IF UNDER 1 YEAR Months <b>3</b> Days <b>22</b> Hours <b>32</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Stock Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Retail</b>	
11. BIRTHPLACE (State or foreign country) <b>E. Rainelle, W. Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank E. Fox</b>		14. MOTHER'S MAIDEN NAME <b>Ruby M. Lindsey</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>232-48-6434</b>	
17. INFORMANT <b>Arden L. Rogers</b>		Address <b>see #2 above</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Shock</b> DUE TO (b) <b>Hemorrhage</b> DUE TO (c) <b>Fractured skull, left arm, pelvis and right femur</b>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Car struck tractor trailer junction U. S. 50 &amp; 219 Highways</b>	
20c. TIME OF INJURY Month, Day, Year <b>5:45 p.m. 8-5-66 19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Highway</b>	20f. (City or town) (County) (State) <b>Oakland (Rural) Garr. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>Oakland, Md. 8-5-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/8/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>End of the Trail Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>E. Rainelle, W. Va.</b>
24. FUNERAL DIRECTOR <b>Gerald D. Minnich</b>		25a. REC'D BY REGISTRAR <b>AUG 9 1966</b>	
ADDRESS <b>Oakland, Maryland</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

1. The first step is to identify the problem or question that needs to be answered. This involves understanding the context and the specific requirements of the task.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

11433

## CERTIFICATE OF DEATH

11427

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>25 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kitzmiller</b>		d. STREET ADDRESS <b>P.O. Box 406-Spring St.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Herbert</b> Middle <b>Lewis</b> Last <b>Sims</b>		4. DATE OF DEATH Month <b>August</b> Day <b>22</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Dec. 19, 1892</b>
9. AGE (In years last birthday) yrs. <b>73</b>		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>8</b> Hours <b>15</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Coal Mines</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Elk Garden, W.Va.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Sims, George</b>		14. MOTHER'S MAIDEN NAME <b>Aronhalt, Minerva</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>217-01-1303</b>	
17. INFORMANT <b>Evelyn Sims, daughter</b>		Address <b>-Kitzmiller, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinomatosis</b> 177X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Carcinoma Prostate</b> DUE TO (c) <b>1 1/2 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>6 mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>MAY</b> , 19 <b>65</b> to <b>Aug. 22</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>8-22-66</b> , 19 <b>66</b> , and that death occurred at <b>1:30 PM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. E. Mance</b>		22b. DATE SIGNED <b>23 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. A. E. Mance</b>		22d. ADDRESS <b>Oakland, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Aug. 25/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>I.O.O.F. Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Elk Garden, Mineral Co.</b>
24. FUNERAL DIRECTOR <b>Amy Mildred Sharpless</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
25b. REGISTRAR'S SIGNATURE <b>W. Ve</b>		DATE <b>AUG 29 1966</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

03411



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

11434

11428

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Garrett</b> MARYLAND				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>			c. LENGTH OF STAY IN 1b <b>DOA</b>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Sang Run</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>				d. STREET ADDRESS 		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <b>RALPH</b> Middle <b>VERNON</b> Last <b>SPIKER</b>				<b>4. DATE OF DEATH</b> Month <b>August</b> Day <b>24</b> Year <b>1966</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>April 15, 1917</b>		9. AGE (In years last birthday) <b>49</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Carpenter</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>Building</b>		11. BIRTHPLACE (County & State, or foreign country) <b>San Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME <b>Walter Scott Spiker</b>				14. MOTHER'S MAIDEN NAME <b>Martha Ellen Lewis</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>			16. SOCIAL SECURITY NO. <b>215-07-9300</b>		17. INFORMANT Address (Widow) <b>Mrs. Ruth F. Spiker, Sang Run, Md.</b>		
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Hemorrhage due to</b> 237X DUE TO <b>Brain tumor</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <b>?</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>1945</b> to <b>24 Aug 66</b> , that (I) (we) lost the deceased alive on <b>24 Aug 66</b> , and that death occurred at <b>12:00 pm</b> in <b>the</b> <b>house</b> and on the date stated above.							
22a. SIGNATURE <b>A. E. Mance</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>24 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. E. Mance, M.D.</b>			22d. ADDRESS <b>Oakland, Maryland</b>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/27/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Pentacostal Church Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Sang Run, Md.</b>		
24. FUNERAL DIRECTOR <b>O. Durst</b>				ADDRESS <b>John O. Durst</b>		25a. REC'D BY REGISTRAR <b>DATE AUG 30 1966</b>	
<b>Leighton-Durst Funeral Home, Oakland, Md.</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1154

UNITED STATES GOVERNMENT

1941

NAME		DATE	
ADDRESS		CITY	
STATE		COUNTY	
ZIP		COUNTRY	
TELEPHONE			
OCCUPATION			
EDUCATION			
MARRIAGE			
CHILDREN			
MILITARY SERVICE			
REMARKS			

UNITED STATES GOVERNMENT  
BUREAU OF THE CENSUS  
WASHINGTON, D. C. 20540

CERTIFICATE OF DEATH

11429

11435

1. PLACE OF DEATH a. COUNTY <b>GARRETT</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>GARRETT</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>			c. LENGTH OF STAY IN 1b <b>9 days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OAKLAND</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>GARRETT COUNTY MEMORIAL HOSPITAL</b>				d. STREET ADDRESS		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>ALICE ELIZABETH THOMPSON</b>				4. DATE OF DEATH Month Day Year <b>AUGUST 27, 19 66</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>APR. 2, 1906</b>		9. AGE (In years last birthday) <b>60</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>NURSE</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>NURSING</b>		11. BIRTHPLACE (County & State, or foreign country) <b>WEST VIRGINIA</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>MONTGOMERY WILSON</b>				14. MOTHER'S MAIDEN NAME <b>MARY STEWART</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT (HUSBAND) <b>EMORY THOMPSON</b>		Address <b>OAKLAND, MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary Edema</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Acute Myocardial Infarct</b> DUE TO (c) <b>Arteriosclerotic Cardio Vascular Disease</b>							INTERVAL BETWEEN ONSET AND DEATH <b>6 hours</b> <b>9 Days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <b>Diabetic Mellitus</b>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 11, 19 57</b> to <b>AUG. 27, 1966</b> , that (I) (we) last saw the deceased alive on <b>AUG. 27, 19 66</b> , and that death occurred at <b>8:55 P M</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Herbert H. Leighton</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>28 Aug 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>HERBERT H. LEIGHTON, M.D.</b>				22d. ADDRESS <b>OAK STREET OAKLAND, MARYLAND</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/30/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Garrett Co. Mem. Gardens</b>		23d. LOCATION (City or Town) (County) (State) <b>Oakland, Maryland</b>	
24. FUNERAL DIRECTOR <b>Gerald D. Minnich</b>				ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal and in any event, within 72 hours after death.

1511

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1  
FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11436

11430

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> <b>MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rural - Swanton</b>		c. LENGTH OF STAY IN 1b <b>20 yrs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Route #1</b>		d. STREET ADDRESS <b>Route #1,</b>	
3. NAME OF DECEASED (Type or print) First <b>LOYAL</b> Middle <b>MALCOLM</b> Last <b>WARNICK</b>		4. DATE OF DEATH Month <b>August</b> Day <b>7,</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 22, 1911</b>
9. AGE (In years last birthday) <b>55</b> yrs.		IF UNDER 1 YEAR Months <b>55</b> Days <b>55</b> Hours <b>55</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Miner</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Soft Coal</b>	
11. BIRTHPLACE (State or foreign country) <b>Garrett Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Harry Warnick</b>		14. MOTHER'S MAIDEN NAME <b>Anna Bray</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>232-26-0298HA</b>	
17. INFORMANT <b>Mrs. Loyal Warnick, Rt. #1, Swanton</b>		Address (Widow)	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> 4201 DUE TO (b) <b>Arteriosclerotic cardiovascular disease</b> Years DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <i>James H. Feaster, Jr.</i>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M. D.</b>		22. DATE SIGNED <b>8-7-66</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>8/10/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Turner Cem.</b>		23d. LOCATION (City, town or county) (State) <b>Rt. 1, Swanton, Md.</b>	
24. FUNERAL DIRECTOR <b>John C. Durst</b>		25a. REC'D BY REGISTRAR <b>AUG 9 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

01130

1941 - 1942

1943 - 1944

1945 - 1946

1947 - 1948

1949 - 1950

1951 - 1952

1953 - 1954

1955 - 1956

1957 - 1958

1959 - 1960

1961 - 1962

1963 - 1964

1965 - 1966

1967 - 1968

1969 - 1970

1971 - 1972

1973 - 1974

1975 - 1976

1977 - 1978

1979 - 1980

1981 - 1982

1983 - 1984

1985 - 1986

1987 - 1988

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If only delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

11437

11431

1. PLACE OF DEATH a. COUNTY <b>Garrett</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Garrett</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland</b>		c. LENGTH OF STAY IN 1b <b>3 hrs. 12 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Oakland (Rural)</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Garrett County Memorial Hospital</b>			d. STREET ADDRESS <b>Rt. 1, Box 107</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Leroy</b> Middle <b>Elsworth</b> Last <b>White</b>			4. DATE OF DEATH <b>August 28th, 19 66</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>1-26-1879</b>	9. AGE (In years lost birthday) <b>87</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Farmer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Farming</b>		11. BIRTHPLACE (State or foreign country) <b>Oakland, Maryland</b>	
13. FATHER'S NAME <b>Franklin White</b>			12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>			16. SOCIAL SECURITY NO. <b>219-01-7847</b>		
17. INFORMANT <b>George White</b>			Address <b>see #2 above</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral vascular accident</b> <b>331X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Arteriosclerosis, generalized</b> DUE TO (c) <b>Years</b>					INTERVAL BETWEEN ONSET AND DEATH <b>3 hrs. 12 min.</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>					
ACTUAL SIGNATURE <b>James H. Feaster, Jr., M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22. DATE SIGNED <b>8-28-1966</b>	
EXAMINER'S NAME (Type) <b>James H. Feaster, Jr., M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
Address (Street, city, town, or county) <b>Oakland, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>8/31/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Red House Luth. Cem.</b>	23d. LOCATION (City or Town) <b>Garrett Co.</b>	(County)	(State) <b>Maryland</b>
24. FUNERAL DIRECTOR <b>Guild N. Minnich</b>		ADDRESS <b>Oakland, Maryland</b>		25a. REC'D BY REGISTRAR <b>SEP 2 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>



1811